Choices for Care Policy & CCU Collaboration with Hospital Discharge Planners

February 7, 2017
Training Objectives

• Understand the Health & Human Services Transformation strategy

• Demonstrate knowledge of federal Preadmission Screening & Resident Review program (PASRR) requirements as they pertain to CCUs and Hospital Discharge Planners

• Demonstrate knowledge of importance and process of pre-screening in reference to Public Act 099-0857, effective 1/1/17

• Understand the Choices for Care policy and the importance of communication and collaboration between CCUs, Hospital Discharge Planners and the Illinois Health and Hospital Association
Terminology & Definitions

Throughout these slides the following terms are used:

• Choices for Care = pre-screening = assessment completed
• NF = Nursing Facility
• SLP = Supportive Living Program provider; SLP = SLF; SLP is updated terminology as it reflects that Supportive Living Program waiver is community & not institutionally based
• DON = Determination of Need; assessment completed by CCU
• PAS agent = entity contracted with Illinois Department of Human Services, Division of Mental Health
• ISC = entity contracted with Illinois Department of Human Services, Division of Developmental Disability
• HFS 2536 = Healthcare & Family Services Interagency Certification of Screening Results
• HFS 3864 = Healthcare & Family Services Screening Verification Form
Drivers of Change to Choices for Care Policy

- State of Illinois Health & Human Service (HHS) Transformation – Focus on Rebalancing

- Compliance with federal Pre-Admission Screening and Resident Review (PASRR) Requirements

- Senate Bill 2929 – Public Act 099-0857
Health & Human Services (HHS) Transformation

• During the 2016 State of the State address, the governor shared the following Transformation Strategy: “Our transformations put a strong new focus on prevention and public health; pays for value and outcomes; makes evidenced-based and data driven decisions; and moves individuals from institutions to community care, to keep them more closely connected with their families and communities.”

• There are four guiding principles:
  – Create a consumer-centric system: All programs, policies, and technologies place individuals and families at the center.
  – Modernize service delivery: Offer the people of Illinois the evidenced-based support they need when they need it and in the communities and settings best suited for them.
  – Pay for Outcomes and Value: Expect evidence-based practices in service delivery that moves from fee-for-service to value based payment.
  – Organize to Deliver: Ensure a strong, streamlined organization, coordinated operations and a workforce skilled to serve the people of Illinois at the right place, at the right time, and with the right care, at the right cost.
HHS Transformation (cont):

Moving from Institutional to Community Based Settings

• Increased Interagency communication & collaboration with IDoA, Healthcare & Family Services (HFS), Department of Human Services (DHS)—Divisions of Mental Health (DMH), Developmental Disability (DDD), and Rehabilitation Services (DRS)

• Focusing on:
  – Synchronizing policies; standardizing forms & eventual electronic data/forms transfer
  – Identifying & applying effective deflection strategies
  – Ensuring short-term facility stays don’t become long-term
  – Deinstitutionalization/Reintegration initiatives post-Money Follows the Person (MFP)
Federal PASRR Requirements

• The State of Illinois’ PASRR program must identify all individuals who are suspected of having mental illness (MI) or intellectual/developmental disability (DD)

• CCUs are required to complete the OBRA Level I Screen

• If there is any suspicion of MI or DD, the CCU makes a referral to the appropriate PAS Agent or ISC

• The PAS agent or ISC will determine if a Level II evaluation is needed; the Level II evaluation determines whether facility services & specialized services are needed
Evolution of SB 2929/Public Act 099-0857

• Previous Public Act 098-0651 established hospital discharge planners as responsible party to assure required pre-screening paperwork sent to facilities

• Senate Bill (SB) 2929 was filed in February 2016; signed into Public Act 099-0857 in August 2016

• For successful pre-screening process, entities involved have to collaborate together
  – Hospitals
  – CCUs
  – Nursing Facilities/Supportive Living Program providers

• Potential breakdown in communication can happen at any level
Public Act 99-0857 (SB 2929): Effective 1/1/17

• When assessments completed in the hospital, CCUs to provide documents to nursing facility prior to discharge.
• IDoA to notify CCUs of new requirements.
• If unable to complete assessment in hospital for patients over age 60;
  – CCU to notify IDoA
  – IDoA to notify HFS
• HFS/IDoA to adopt rules to address these instances to ensure participant able to access nursing facility care. (facility not penalized for accepting admission & not delaying hospital discharge).
• New language does not preclude federal requirements for PAS/Mental Health screen as required under Nursing Home Care Act Section 2-201.5.
CCUs & Hospital Discharge Planners working together

• Timeliness in informing CCUs of hospital discharges to ensure patient/family can learn of community-based options/services (24-hour notice minimum)
  – CCUs prescreens ages 18-59 for DRS
  – CCUs prescreens ages 60 and older for DoA

• Ensure compliance with federal PASRR requirements

• Hospital Discharge Planner share SSN with CCU

• Identify address of NF/SLP patient will be discharging to ensure documentation can be sent by CCU as required
  – CCU leave copy of paperwork with Hospital Discharge Planner as needed
What is the Purpose of Pre-Screening?

- The goal of pre-screening is to divert the person from unnecessary placement by offering information about services in the community.
- Participants have the right to choose home and community based services, a Nursing Facility (NF) or Supportive Living Program provider (SLP).
- Minimum of 29 total points on the DON is required for eligibility for CCP, NF, or SLP.
- Requirements of Federal PASSR program to identify all individuals who are suspected of having mental illness (MI) or intellectual/developmental disability (DD).
  - The PAS agent or ISC will determine if a Level II evaluation is needed; the Level II evaluation determines whether facility services & specialized services are needed.
What is the Process for Pre-Screening?

Referral & Checking for Previous DON

1) Referral can come from hospital, SLP, NF, community, individual/family

2) CCU checks agency’s Case Management Information System (CMIS) AND either IDoA’s electronic Community Care Program Information System (eCCPIS) or Participant Search Screen (PSS)

3) 1st Question—has a DON been completed within the past 90 calendar days?
   - If no, CCU conducts face to face screening
What is the Process for Pre-Screening?

Checking for Previous DON

Has a DON been completed within the past 90 calendar days?

4) If **yes**, CCU does not complete another screening

5) CCU completes HFS Screening Verification Form (HFS 3864), hand write DON score onto form

6) CCU determines if there is suspicion of MI and/or DD & completes OBRA Level I Screen

   - If no suspicion of MI and/or DD, CCU sends HFS 3864 & OBRA Level I Screen to entity
   - If suspicion of MI, CCU makes referral to appropriate PAS agent within one day, hand write DON score on OBRA Level I Screen
   - If suspicion of DD, CCU makes referral to appropriate ISC within one day
   - If suspicion of MI or DD, CCU informs referring entity (hospital, NF, SLP, etc.) that referral has been made to PAS agent or ISC
What is the Process for Pre-Screening?

Need for Interim or Temporary Service Increase (TSI):

• DON completed within last 90 calendar days but individual is returning home & in need of CCP
• CCU may complete another DON if previous DON will not assure appropriate plan of care
• If individual is in an MCO, CCU shall refer individual to their MCO

(No difference from previous policy)
What is the Process for Pre-Screening?

When individual is in the hospital

1. Hospital is required to notify CCU at least 24 hours prior to discharge (or sooner)
2. CCU completes pre-screening within 1 calendar day of notification from hospital
3. CCU has capacity to complete face to face pre-screenings 7 days a week, at a minimum of 7 business hours per day; CCU documents the time the request was received & the time pre-screening was completed
4. CCU follows up on all hospital notifications of patients pending discharge with home health services ordered; CCU completes intake/referral in accordance with CCU’s policies/procedures
5. When hospital notifies CCU of individual’s discharge date & NF/SLP entered, CCU sends paperwork to the NF/SLP
What is the Process for Pre-Screening?

When individual is in the community

1st question—is the individual at imminent risk (within 3 calendar days) of NF/SLP placement?

1. If yes, pre-screening must be completed within 1 calendar day

1. If no, pre-screening must be completed within 2 calendar days
Completion of OBRA Level I Screen

*CCU completes OBRA Level I Screen:
1. During face to face pre-screening
2. Regardless of whether DON completed within 90 calendar days
3. If no indication of MI or DD, CCU sends copy of OBRA Level I Screen to NF/SLP
4. *Hospital staff may also complete the Level I screen and refer directly to MH PAS agent or DD ISC.
What is the Process for Pre-Screening?

OBRA Level I Screen
Indicates Suspicion of Mental Illness

1. CCU completes DON (if no previous DON or DON greater than 90 calendar days) & *OBRA Level I Screen (*may be completed by hospital staff)
2. CCU writes DON score on OBRA Level I Screen
3. CCU contacts PAS agent within one day to make referral
4. CCU informs referring entity (hospital, NF, SLP) that referral to PAS agent made
5. PAS agent informs CCU if need for further evaluation (OBRA Level II Screen)
6. If no Level II completed by PAS agent, CCU completes HFS 2536
7. If PAS agent will be conducting Level II, PAS agent completes HFS 2536
What is the Process for Pre-Screening?

OBRA Level I Screen
Indicates Suspicion of Intellectual/Developmental Disability

1. CCU completes OBRA Level I Screen
   - May be completed by hospital staff
2. CCU does NOT complete DON
3. CCU contacts ISC within one day to make referral
4. CCU informs referring entity (hospital, NF, SLP) that referral to ISC made
5. ISC informs CCU if need for further evaluation (OBRA Level II Screen)
6. If no Level II completed by ISC, CCU completes DON & HFS 2536
7. If ISC will be conducting Level II, ISC completes HFS 2536
When Prescreens not Completed: Data Gathering

- If a prescreen was not completed in the hospital, CCU in geographic area of NF/SLP will complete post-screening within 2 calendar days
- For any instance in which a pre-screening was not completed prior to NF/SLP admission, the CCU includes information about the individual on the spreadsheet compiled by IDoA
  - Hospital is also noted to ensure timeliness of referrals
- Individuals recorded on spreadsheet even if one of the circumstances of the HFS 2536 is met: out of state, from hospital emergency room/outpatient services, or due to loss of a caregiver when a pre-existing need for a caregiver existed
- Each CCU required to send spreadsheet to IDoA weekly
- IDoA shares this spreadsheet to HFS Bureau of Long Term Care and collaborates to improve process
REMINDERS

No forms/documents should **EVER** be backdated.

This Power Point does not include all information from the Choices for Care Policy – please refer to the policy especially for when a prescreen is/is not required.
## Pre-screening Timeframes for CCUs: Next Steps

<table>
<thead>
<tr>
<th>Type of Screen</th>
<th>New Required Timeframe</th>
<th>Previous Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Based Screen &amp; Community Based Imminent Risk Screen</td>
<td>1 calendar day; CCUs must have capacity to complete pre-screening 7 days a week, 7 hours a day</td>
<td>2 calendar days</td>
</tr>
<tr>
<td>Community Based Non-Imminent Risk Screen</td>
<td>No change—2 calendar days</td>
<td>2 calendar days</td>
</tr>
<tr>
<td>All Post-Screening</td>
<td>2 calendar days</td>
<td>10 calendar days</td>
</tr>
<tr>
<td>CCU referral to MH PAS agent or DD ISC</td>
<td>within one day of completion of OBRA Level I Screen</td>
<td>not addressed</td>
</tr>
<tr>
<td>Verification of Screen (HFS 3864) to NF/SLP upon request</td>
<td>No change—10 calendar days</td>
<td>10 calendar days</td>
</tr>
<tr>
<td>Case Authorization Transaction (CAT) entered into system</td>
<td>No change--10 calendar days of completion of pre-screening</td>
<td>10 calendar days of completion of pre-screening</td>
</tr>
</tbody>
</table>

**Note:** These are maximum timeframes
Follow Up After Individual Enters Nursing Facility

• Short-term Placement with Follow-up:
  – All individuals being placed in a NF for a short period of time for rehabilitation (less than 60 calendar days), are to be offered the opportunity for a Care Coordinator to visit them in the NF prior to the planned discharge date, in order to facilitate the discharge, if appropriate (Service Selection and Certification form).

• Out of Area Follow-up:
  -- If the individual is going to a NF which is not in the CCU service area, the CCU shall forward within five (5) workdays, the CCP Screening Information Form, Part I, to the CCU in the area in which the NF is located.
Follow Up After Individual Enters Nursing Facility

Deinstitutionalization (DEI):

-- DEI refers to the assessment process and return of an individual to the community following NF placement for more than sixty (60) calendar days, and when the intent of admission was not based on temporary rehabilitation purposes. Requests may come from DHS/DRS.

-- CCU conducts DEI screen within fifteen (15) workdays. Qualify for Transitional Services.

-- *Prior to June 30, 2017, Contact CCU MFP Transition Coordinator.
Looking Forward

• IDoA, HFS webinar on Choices for Care with NFs and SLPs
• IDoA will work with HFS to give Participant Search Screen access to Hospital Discharge Planners and NFs/SLP providers
• IDoA working on streamlining IT system for all entities involved in the pre-screening process (hospitals, CCUs, NFs, SLP providers) to improve communication and collaboration
• Information shared by CCUs for when pre-screenings not completed will collect data & allow IDoA to work with partners to target specific areas/regions of concern
Ongoing Communication

• To report any questions you may encounter when interacting with your CCU partners, please share them at:

Aging.OCCS@illinois.gov

THANK YOU